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	085021	A. BUILDING _____ B. WING _____	07/19/2011

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MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

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F 000	INITIAL COMMENTS An unannounced annual survey was conducted at this facility from July 12, 2011 through July 19, 2011. The deficiencies contained in this report are based on observations, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 89. The survey Stage 2 sample totaled thirty-four (34) residents.	F 000	**This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Millcroft agrees with the allegations and citations listed on the statement of deficiencies. Millcroft maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Millcroft's written credible allegation of compliance.** **By submitting this plan of correction, Millcroft does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Millcroft reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.**	
F 166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. This REQUIREMENT is not met as evidenced by : Based on interviews, and review of facility investigation documentation and facility policy/ procedure, it was determined that the facility failed to investigate, document, and follow up on a grievance for one resident (R169) regarding a missing item. Findings include: On 07/13/11, in an interview with R169's family member (responsible party), the family reported a bedspread (belonging to R169) missing for two months. R169's family member stated she had reported the bedspread missing to a facility staff three weeks ago, filled out a missing item form, and had not heard anything from the facility regarding the missing bedspread. On 7/15/11, in an interview with E10 (Nurse) and	F 166	**F 166** 1. R169's missing property was found during the survey. 2. All residents have the potential to be affected by similar incidents.	9/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/8/11

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 166	Continued From page 1 E7 (Social Services Director), E10 stated that the family member had reported R169's bedspread missing to her and she searched in the laundry unsuccessfully. E10 stated she reported the missing item to her nursing supervisor and placed the missing item form completed by the family member under E7's office door for her follow up as per facility procedures. E7 denied she received the missing form and was unaware of R 169's missing bedspread. On 7/15/11, E7 was observed calling the family member and confirmed the bedspread was still missing. In an interview with E8 (Director of Housekeeping) on 7/15/11, she stated she would look for the missing bedspread in the laundry again. The facility procedure for grievances/missing items was reviewed. The missing item form completed by the family member or any other incident report for R169's bedspread was not found. Interview with E7 on 7/19/11 revealed that they found a bedspread in the laundry and would verify with R169's family member if it was the missing bedspread. The facility failed to promptly follow up, or address, a grievance resulting from a resident's missing item.	F 166	3. Managers and nursing supervisors will be re-trained on the facility's Missing Property Policy and proper reporting and documentation. Training will be done by the Staff Development Coordinator and/or designee. The Social Service Director will be responsible for reviewing the logging the reports and assigning to the appropriate manager for review and follow-up. The Assistant ED will conduct random weekly audits of reports for the first month and the monthly for 6o days. Findings will be reported to Administrator for follow-up and corrective action if needed. 4. The results of the audits will be reviewed by the QA Committee for the next 90 days as a means of assuring ongoing compliance	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241		

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F 241	Continued From page 2 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by : Based on observations and staff interviews, it was determined that the facility failed to promote care for two (R27 and R155) out of 34 sampled residents in a manner and in an environment that maintained or enhanced the resident's dignity and respect. 1. Observations on 7/15/11 at 12:15 PM with E7 (Social Services Director) revealed R27 being pulled in her Geri chair backwards down the hallway to the dining room by E9 (Nurse). E14 (Staff Development Coordinator, RN) confirmed this finding during an interview on 7/19/11 and stated that she addressed this topic during a dignity in-service to the staff. 2. On 7/13/11 at 11:02 AM, during a resident interview, R155 stated that staff often don't treat him with respect. R155 gave the example that he was often told, "hurry up, I have other people to do ..." when being showered. He was unable to recall which staff rushed him. On 7/15/11 at 12 PM, R155 was observed with his lunch tray on the table beside his bed. R155 stated that he was not feeling good and he stated that he did not want to eat what was on his tray and he preferred to have "a little soup". During an observation on 7/15/11 at 12:25 PM, E 16 (CNA) came to R155's room at the surveyor's request and asked R155 if he was finished with his tray. R155 started to explain that he would like	F 241	**F241** 1. R27 remains in the facility and had no negative outcome from the incident noted. Once notified of the incident E9 was re-educated on treating residents with Dignity and Respect on 7/15/11. Resident 155 remains in the facility and E16 will be provided coaching and given in-service education on proper the treatment of residents. 2. All resident have the potential to be affected. 3. All direct care and license staff will be provided In-service education on treating residents with Dignity and Respect. Daily shift rounds will be conducted by the nursing supervisors on all residents to ensure that they are being treated with respect. Findings will be discussed in daily standup with immediate corrective action taken.	9/5/11

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F 241	Continued From page 3 some soup and he was still talking to E16 who was halfway out the door with one foot in the hallway. R155 appeared very frustrated and stated to the surveyor, "See what I mean... they don't give me time to finish.. .I need to calm myself down." E16 was stopped by the surveyor and returned, but R155 could not remember what he was saying. During an interview on 7/15/11 at 2:45 PM, E16 confirmed that she did walk out while R155 was still talking and stated that there was "alot going on today... call lights ringing...". The facility failed to care for R155 in a manner that maintained his dignity when they did not allow him to finish talking before they started to leave his room.	F 241	4. Random observations/ interview rounds will be conducted by the department managers weekly to ensure compliance with resident rights. Rounds will be ongoing. Results will be Discussed in the monthly QA meeting as a means of assuring on going compliance correction action will be taken as warranted.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by : Based on clinical record review and staff interviews, it was determined that the facility failed to ensure that the necessary care and services were provided to attain or maintain the highest practicable physical well being in accordance with the physician's order for one (1)	F 309	**F 309** 1. R43 is no longer in the facility and was discharged home with No negative outcome from incident. R34's medication Administration record was reviewed and staff identified as not following parameters as per the Physician orders will be given corrective action and in-service education on proper monitoring and documentation of medications with parameters.	9/5/11

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F 309	Continued From page 4 resident (R43) out of 34 sampled residents Findings include: R43 had a physician's order, dated 5/26/11, for Metoprolol 25 mg tablet take 1/2 tablet (12.5mg) by mouth twice a day (8 AM and 5 PM) for hypertension with parameters to hold (not administer) for SBP (Systolic Blood Pressure) less than 110, and/or HR (Heart Rate) less than 65. Review of R43's June 2011 MAR (Medication Administration Record) revealed that on 6/7, 6/8, 6/21, 6/22, and 6/28, the 5 PM dose was administered when it should have been held per HR parameters and on 6/4/11 at 5 PM, it was administered when it should have been held per SBP parameter. Review of R43's July 2011 MAR (Medication Administration Record) revealed that Metoprolol (retimed for 8 AM and 8 PM) on 7/2 and 7/3, the 8 PM doses and on 7/8, 7/9, and 7/10, the 8 AM doses were administered when they should have been held per HR parameters. Findings were discussed on 7/19/11 during the informational meeting with E2 (Assistant Executive Director), E3 (Director of Nursing) and E4 (Corporate Nurse). The facility administered R 43's Metoprolol six times out of thirty days in June and five times out fifteen days in July, despite the physician's order to hold the medication if R43's HR or SBP were outside of the ordered parameters. The facility failed to follow the physician's order when administering R43's blood pressure medication.	F 309	2. All residents with medication parameters have the potential to be affected. 3. All licensed staff will be provided in-service education on proper medication administration and monitoring of parameters. 4. Weekly audits will be conducted on 10% of the facility's resident population that have Physician orders with parameters then on going monthly to ensure compliance audits will be done by the DON/Designee Results of the audits will be reviewed by the QA for 90 days as a means of assuring ongoing compliance. Corrective action will be taken if needed.	

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/ SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by : Based on observations it was determined that the facility failed to maintain an environment free of accident hazards by having unsecured chemical storage. Findings include: 1.Observation on 7/12/11 of the second floor shower room revealed the unsecured storage of three 8 oz .opened bottles of body wash in the shower, two 8 fl .oz. bottles of skin moisturizer, one 1.5 container of shaving cream, one 8 fl. oz. open bottle of rinse free shampoo and two 8 fl .oz . spray bottles of wound cleaner. All were marked for external use only.	F 323	**F323** 1. No residents were identified upon notification of incident. All chemicals noted were immediately secured. 2. All residents have the potential to be affected. 3. All direct care staff will be provided in-service on proper storage of chemicals and maintaining a safe environment. Unit rounds will be conducted by the unit managers/supervisors at the beginning and end of each shift to ensure Compliance. 4. Random weekly of the shower rooms audits will be conducted by the Housekeeping Manager/Designee for 1 month then ongoing monthly for the next 60 days to ensure compliance. Findings will be discussed in the Monthly QA with corrective action taken action as warranted.	9/5/11
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.	F 329		9/5/11

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F 329	Continued From page 6 Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by : Based on record review and interview, it was determined that the facility failed to ensure that three (3) residents' (R43, R112, and R140) drug regimens were free from unnecessary drugs. R 112 lacked evidence of required adequate laboratory monitoring for iron and diuretic medications. R43 and R140 lacked documented evidence of non-pharmacological behavior interventions prior to the use of PRN (as necessary) antipsychotic medications and the effectiveness of the medications when administered. Findings include: The facility's "Medication Monitoring" policy was reviewed. 1. R112 had diagnoses that included chronic kidney disease, multiple pressure wounds, anemia and edema. R112 was admitted to the	F 329	**F329** 1. R43 and R112 are no longer in the facility. R140 remains in the facility with no negative outcome from the identified practice. A medication review will be completed on R140 to determine the continual need for prn Psychoactive medication. 2. All residents with prn orders for Antipsychotic medications have the potential to not have adequate Monitoring and Non-pharmacological Interventions utilized prior to Administration of medication. 3. All license staff will be provided in-service trianing on the proper utilization of the Behavior Flow sheet and appropriate documentation of behaviors, use of non-pharmacological intervention and documentation of Psychoactive drug effectiveness when given.	9/5/11

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F 329	Continued From page 7 facility on 06/10/11. Review of R112's clinical record revealed the following physician's orders that required laboratory monitoring: a. Physician's order dated 06/10/11- Ferrous sulfate 325 (65) mg 1 tablet by mouth daily (for iron deficiency anemia). According to the Pharmacist's "Admission Medication Regimen Review", dated 6/10/11, the Required Laboratory Monitoring included HCT/HGB (Hematocrit/ Hemoglobin) within 30 days of initiating iron therapy if not performed within the last 30 days. There was a lack of evidence that the recommended HCT/HGB was done. In an interview with E9 (RN) on 7/18/11, he confirmed that the pharmacy's recommendation was overlooked. Subsequently, E9 immediately notified the physician and a telephone/verbal order was received by E9 (RN) on 7/18/2011 for the HGB/HCT to be done on the next scheduled laboratory day. b. Physician's order dated 6/10/11-Lasix 40 mg. tablet twice a day (diuretic therapy for edema) required laboratory monitoring for a serum potassium level per the pharmacy review on 6/10/ 11. There was a lack of evidence that a potassium level was done. In an interview with E9 (RN) on 7/19/11, he confirmed this finding. 2. R 140 had physician orders for Xanax three times a day as needed for anxiety and Ambien at bedtime as needed for insomnia. Review of R140's care plans for anxiety and insomnia, dated 12/22/10 (last updated on 4/22/	F 329	4. The DON/Designee will audit the behavior flow sheets weekly for 1 month on all residents receiving prn psychoactive medication then ongoing monthly on 10% of the resident population of those residents receiving prn antipsychotic medications to ensure compliance. Findings Will be reported in the monthly QA Meeting With corrective action taken as needed..	

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F 329	Continued From page 8 11) listed interventions to "... Monitor response to all interventions" and "... Evaluate effectiveness of hypnotic/sedative", respectively. Review of the medication administration records (MARs) revealed that R140 received the following number of doses of medication: May 2011- Xanax- 16 Ambien- 7 June 2011- Xanax- 14 Ambien- 7 July 2011- Xanax- 10 Ambien- 7 The backs of the 5/11- 7/11 MARs were blank; they lacked documentation of the effectiveness of the medications. Review of Behavior/Intervention Monthly Flow Records (behavior sheets) from 5/11-7/11 revealed that the facility rarely documented the number of episodes of behavior, non-pharmacologic interventions used, and the effectiveness of the medications. Nurse's notes were reviewed on the dates when Xanax was administered in May 2011. The only nurse's note with information related to Xanax was 5/29/11, however, the note lacked non-pharmacologic interventions utilized by the facility prior to the administration of Xanax.	F 329		

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F 329	Continued From page 9 E3 (Director of Nursing) confirmed findings during an interview on 7/15/11. E3 stated that the behavior sheets should reflect appropriate documentation and she stated that the 6/11 behavior sheet (there were no documented episodes of behavior that required Xanax and Ambien to be given) made it look as if the resident did not need the medication. 3. R43's physician order, dated 5/27/11, for Lorazepam 0.5 mg tablet stated to take 1 tablet by mouth 3 times a day prn (as needed) for anxiety. Review of R43's June 2011 MAR (Medication Administration Record) revealed that it was administered on evening shift on nine (9) out of thirty (30) days. Review of the June Behavior/ Intervention Monthly Flow Record, the back of the MAR and the nurse's notes lacked evidence that the facility attempted non pharmacological interventions prior to medicating R43 on four (4) of nine (9) days. Additionally, R43's nurse's notes revealed only one (1) entry, dated 6/29/11 at 11 PM, of the effectiveness of the Lorazepam. This review lacked evidence of monitoring the effectiveness of the Lorazepam administered on five (5) of nine (9) evenings. Review of R43's July MAR revealed that Lorazepam was administered as prn doses on eleven (11) of thirteen (13) days. Review of the back of the MAR revealed only one entry, dated 7 /2/11, of the effectiveness of the Lorazepam administered. Review of the nurse's notes lacked evidence of monitoring the effectiveness of the medication administered. Review of the July Behavior/Intervention Monthly Flow Record and	F 329		

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F 329	Continued From page 10 nurse's notes lacked evidence that the facility attempted non pharmacological interventions prior to medicating R43 on any of the eleven (11) days it was administered in July. Review of R43's "Anxiety" care plan, dated 5/9/11 , included both non-pharmacological and pharmacological approaches. Additionally, one of the approaches stated, "Monitor response to all interventions." Findings were discussed on 7/19/11 during the informational meeting with E2 (Assistant Executive Director), E3 (Director of Nursing) and E4 (Corporate Nurse). The facility failed to utilize non-pharmacological interventions prior to administering prn doses of Lorazepam and they failed to monitor the effectiveness of R43's medication.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by : Based on observation, record review and interview, it was determined that the facility failed to ensure that one (R214) out of 34 sampled residents were free from significant medication errors. Findings include: Review of the MAR (Medication Administration Record) for July 2011, revealed that R214 had an order for Diovan 80mg, take 1 tablet by mouth every day (hold for SBP (systolic blood pressure)	F 333	**F333** 1. R 214 is currently not in the facility but upon R214's return, his medication will be reviewed to ensure parameters are being followed as per orders. E22 is no longer employed by the facility. 2. All residents with medication parameters have the potential to be affected. 3. All license staff will be provided in-service education on proper Medication Administration and monitoring of Parameters. Training will be done by the DON and/or designee.	9/5/11

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F 333	Continued From page 11 <100. R214 also had an order for Labetalol 100 mg, 1 tablet by mouth twice a day (hold for SBP < 100 & HR (Heart Rate) <50. Observation of medication administration on 7/15/11 with E22 (LPN) revealed that she attempted to give R214 Diovan and Labetalol without first obtaining a blood pressure and heart rate, but she was stopped by surveyor. E22 confirmed findings on 7/15/11.	F 333	4. Weekly audits by the DON and/or designee will be conducted on 10% of the facility's resident population that have Physician Orders with parameters to ensure compliance times. Audits will be done for 1 month and immediate corrective action will be taken and reported to the QA committee.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/ SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by : Based upon review of staff documentation and interview, it was determined that the facility failed to prepare, distribute and serve food to the residents under sanitary conditions. Findings include: Review of Food Employee health forms revealed that the facility failed to review with newly hired dietary employees (E11, E12 and E13) to determine if they had the Norovirus illness, which would prevent them from working with food. The	F 371	**F 371** 1. E11, E12 and E13 are still in the facility and will be rescreened using the new Food Employee Health Form. No residents had any negative outcomes because the wrong form was used. 2. All residents have the potential to be affected by this practice. 3. New form has been downloaded and will be used for all new hires and appropriate action will be taken if needed. The dietitian will periodically access the State web site to assure the correct form is being used.	9/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	07/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILLCROFT	255 POSSUM PARK ROAD NEWARK, DE 19711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 12 health forms did not include Norovirus. E11 and E 13 were hired on 4/25/11. E12 was hired on 05/09 /11. E6 (Human Resource Director) confirmed this finding on 7/15/11 and E5 (Food Services Director) confirmed this finding on 7/18/11.	F 371	4. The Director of Food Service will conduct random audits of newly hired dietary employees for the next 6o days to assure compliance. Corrective action will be taken.	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	F 441	**F441** 1. R 81 remains in the facility and had no negative outcome from identified practice. E22 is no longer employed by facility. 2. All residents that receive eye drops have the potential to be affected by this practice. 3. All license staff will be provided in-service education on proper hand washing during medication administration and correct procedure for instilling eye drops. Training will be done by the DON and/or designee.	9/5/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	085021	A. BUILDING _____ B. WING _____	07/19/2011

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F 441	Continued From page 13 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by : Based on observations and interview, it was determined that the facility failed to maintain infection control practices designed to provide a safe, sanitary and comfortable environment, and to help prevent the development and transmission of disease and infection for one (R 81) out of 34 sampled residents. Findings include: An observation on 7/15/11 of E22 (LPN) during medication administration revealed that she gave R81 an insulin injection while wearing gloves, then proceeded to administer eye drops without taking off the gloves or washing her hands. Upon administering the eye drops, E22 blotted both eyes with the same area of the tissue. Review of the facility policy, dated 3/06, stated that hands are washed before and after the administration of ophthalmic medications. Findings were discussed on 7/15/11 with E3 (Director of Nursing) and E4 (Corporate Nurse).	F 441	4. Random medication observations will be done monthly by the DON/Designee for 3 months then quarterly to ensure compliance. Findings will be discussed in the QA meeting with corrective action taken if needed.	9/5/11

DELAWARE HEALTH AND SOCIAL SERVICES
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STATE SURVEY REPORT

NAME OF FACILITY: Millcroft

DATE SURVEY COMPLETED: July 19, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	An unannounced annual survey was conducted at this facility from July 12, 2011 through July 19, 2011. The deficiencies contained in this report are based on observation, interviews, review of residents' clinical records and review of other facility documentation as indicated. The facility census the first day of the survey was 89. The survey Stage 2 sample totaled thirty-four (34) residents.	This plan of correction is prepared and executed because it is required by the provisions of the state and federal regulations and not because Millcroft agrees with the allegations and citations listed on the statement of deficiencies. Millcroft maintains that the alleged deficiencies do not, individually and collectively, jeopardize the health and safety of the residents, nor are they of such character as to limit our capacity to render adequate care as prescribed by regulation. This plan of correction shall operate as Millcroft's written credible allegation of compliance. By submitting this plan of correction, Millcroft does not admit to the accuracy of the deficiencies. This plan of correction is not meant to establish any standard of care, contract, obligation, or position, and Millcroft reserves all rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.
3201 3201.1.0 3201.1.2	**Regulations for Skilled and Intermediate Nursing Facilities** **Scope** **Nursing facilities shall be subject to all applicable local, state and federal code requirements. The provisions of 42 CFR Ch. IV Part 483, Subpart B, requirements for Long Term Care Facilities, and any amendments or modifications thereto, are hereby adopted as the regulatory requirements for skilled and intermediate care nursing facilities in Delaware. Subpart B of Part 483 is hereby referred to, and made part of this Regulation, as if fully set out herein. All applicable code requirements of the State Fire Prevention Commission are hereby adopted and incorporated by reference.** **This requirement is not met as evidenced by:** Cross refer to the CMS 2567-L survey report date completed 7/19/11, F166, F241, F309, F323, F329, F333 and F441.	**3201.1.2 Cross reference CMS 2567-L survey report date completed 7/19/2011 for F 166, F 241, F 309, F 323, F 329 and F441. This is our Plan of Correction. Completion date 9/5/2011**
3201.7.5	**Kitchen and Food Storage Areas**	

Provider's Signature _____ Title Administrator Date 8/8/11

NAME OF FACILITY: Millcroft

DATE SURVEY COMPLETED: July 19, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	Facilities shall comply with the 2011 Delaware Food Code. **2-201.11 Responsibility of Permit Holder, Person in Charge, and Conditional Employees.** **(A) The permit holder shall require food employees and conditional employees to report to the person in charge information about their health and activities as they relate to diseases that are transmissible through food. A food employee or conditional employee shall report the information in a manner that allows the person in charge to reduce the risk of foodborne disease transmission, including providing necessary additional information, such as the date of onset of symptoms and an illness, or of a diagnosis without symptoms, if the food employee or conditional employee:** ***reportable symptoms*** **(1) Has any of the following symptoms:** **(a) Vomiting,** **(b) Diarrhea,** **(c) Jaundice,** **(d) Sore throat with fever, or** **(e) A lesion containing pus such as a boil or infected wound that is open or draining and is:** **(i) On the hands or wrists, unless an impermeable cover such as a finger cot or stall protects the lesion and a single-use glove is worn over the impermeable cover,** **(ii) On exposed portions of the arms, unless the lesion is protected by an impermeable cover, or** **(iii) On other parts of the body, unless the lesion is covered by a dry, durable, tight-fitting bandage; reportable diagnosis**	**3201.7.5 Cross reference CMS 2567-L survey report date completed 7/19/2011 for F 371. This is our Plan of Correction. Completion date 9/5/2011**

NAME OF FACILITY: Millcroft

DATE SURVEY COMPLETED: July 19, 2011

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	(2) Has an illness diagnosed by a health practitioner due to: **(a) Norovirus,** **(b) Hepatitis A virus,** **(c) Shigella spp.,** **(d) Enterohemorrhagic or Shiga toxin-producing Escherichia Coli, or** **(e) Salmonella Typhi; reportable past illness** **(3) Had a previous illness, diagnosed by a health practitioner, within the past 3 months due to Salmonella Typhi, without having received antibiotic therapy, as determined by a health practitioner; reportable history of exposure** **(4) Has been exposed to, or is the suspected source of, a confirmed disease outbreak, because the food employee or conditional employee consumed or prepared food implicated in the outbreak, or consumed food at an event prepared by a person who is infected or ill with:** **(a) Norovirus within the past 48 hours of the last exposure,** **(b) Enterohemorrhagic or Shiga Toxin-Producing Escherichia Coli, or Shigella spp. within the past 3 days of the last exposure,** **(c) Salmonella Typhi within the past 14 days of the last exposure, or** **(d) Hepatitis A virus within the past 30 days of the last exposure; or** **Reportable history of exposure** **(5) Has been exposed by attending or working in a setting where there is a confirmed diseased outbreak, or living in the same household as, and has knowledge about, an individual who works or attends a setting where there is a confirmed.** **This requirement is not met as**	

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NAME OF FACILITY: Millcroft **DATE SURVEY COMPLETED: July 19, 2011**

SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
16 Del. C., Chapter 11, Subchapter VII, §1162	**evidenced by:** Cross refer to the CMS 2567-L survey report date completed 7/19/11, F371. **Nursing Staffing** **(a) Every residential health facility must at all times provide a staffing level adequate to meet the care needs of each resident, including those residents who have special needs due to dementia or a medical condition, illness or injury. Every residential health facility shall post, for each shift, the names and titles of the nursing services direct caregivers assigned to each floor, unit or wing and the nursing supervisor on duty. This information shall be conspicuously displayed in common areas of the facility, in no fewer number than the number of nursing stations. Every residential health facility employee shall wear a nametag prominently displaying his or her full name and title. Personnel hired through temporary agencies shall be required to wear photo identification listing their names and titles.** **This requirement is not met as evidenced by:** Observations of E17 (nurse), E18 (CNA) and E19 (CNA) during the third shift on 7/15/11 revealed that they were not wearing their identification tags. Interviews on 7/15/11 with E17, E18 and E19 revealed they had their identification tag on their pockets or pocketbook. On 7/18/11 at 10:00 AM, a new volunteer activity staff (E20) was observed without an identification tag. On 7/18/11, in an	**16 Del C.;** **Chapter 11, subchapter V11, §1162** 1. No resident identified in this practice. E17, E18 and E19, were provided corrective action and educated on Facility policy on the need for proper Name Identification when reporting to work. E20 has been given a name badge. 2. All residents have the potential to be affected. 3. All employees and new hires will be provided in-service education on facility work rules and State Regulations and the importance of wearing name badges daily. Daily managerial rounds of staff will be conducted on each shift to ensure name badges are being displayed. Corrective action will be taken.

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SECTION	STATEMENT OF DEFICIENCIES Specific Deficiencies	ADMINISTRATOR'S PLAN FOR CORRECTION OF DEFICIENCIES WITH ANTICIPATED DATES TO BE CORRECTED
	interview with E21 (Activity staff), stated that E20 had started two days ago and would request that she use tape to identify her name.	4. Ongoing observation rounds will be conducted by Managers/supervisors on duty to ensure compliance. Immediate corrective action will be taken for those staff identified without Name Badges. Results will be shared with the QA Committee for the next 60 days to assure on going compliance. **Completion Date: 9/5/2011**